

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06423

## 330 CERTIFICATE OF DEATH

Item 2 FilmG238 1-29-59 et

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

CAROLINE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

RURAL GREENSBORO

LENGTH OF STAY  
(In this place)

4 mos

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Daughter's home

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND

COUNTY

CAROLINE

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

DENTON

(If rural give location)

STREET  
ADDRESS3. NAME OF  
DECEASED

(Type or Print)

WALTER JEROME COFFEE

(First) (Middle) (Last)

## 4. DATE (Month) (Day) (Year)

JAN 21, 59

5. SEX

M

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

widowed

8. DATE OF BIRTH

June 8, 1870

9. AGE last birthday

88 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Farm owner

10b. KIND OF BUSINESS  
OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME

WILLIAM A. COFFEE

## 14. MOTHER'S MAIDEN NAME

EMILY GILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

RAY COFFEE, DENTON, MD

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X IMMEDIATE CAUSE (A)

Arterio Sclerosis General

INTERVAL BETWEEN  
ONSET AND DEATH

3 yr -

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

Cerebral Sclerosis

4 mos

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
White  Not white   
M. at work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from.....

alive on.....1-21, 1959, to.....1-21, 1959, that death occurred at.....S.P.M., from the causes and on the date stated above.

SIGNATURE

Dawson George

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

1-23-59

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF

Jan. 24, 1959

NAME OF CEMETERY OR CREMATORIAL

DENTON

LOCATION (City, town, or county)

DENTON, MD.

(State)

24. REC'D BY REGISTRAR

JAN 27 '59

REGISTRAR'S SIGNATURE

John S. Thorne

25. FUNERAL DIRECTOR'S SIGNATURE

George Moorehead Denton Md

ADDRESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00424

431

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maryland		c. LENGTH OF STAY IN 1b 25 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maryland	
3. NAME OF DECEASED (Type or print) Cecil		First Middle Elliott Demby	4. DATE OF DEATH Month 1 Day 1 Year 59 19
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Dover, Delaware
13. FATHER'S NAME Leon Demby		14. MOTHER'S MAIDEN NAME Grace B. Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Leon Demby Address Marydel, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO <i>Brucellosis Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Exposure</i> (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20 <i>20</i>	
20c. TIME OF INJURY Hour o. m. p. m.	1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 31, 1958</i> , to <i>Dec 31, 1958</i> , that I last saw the deceased alive on <i>Dec 31, 1958</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <i>Padwell</i> DATE SIGNED <i>Padwell</i> <i>Dec 31, 1958</i>			
ACTUAL SIGNATURE <i>Padwell</i>		PHYSICIAN'S NAME (Type) <i>Padwell</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/59	22c. NAME OF CEMETERY OR CREMATORIAL Blanco	22d. LOCATION (City, town, or county) (State) Hartly, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS <i>9 VVVVVVV XV V. C. Metcalfe Edgewater</i>	24a. REC'D. BY REGISTRAR JAN 5 '59 DATE
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

CERTIFICATE OF DEATH

REGISTRATION

DEATH CERTIFICATE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00425

432

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		c. LENGTH OF STAY IN 1b <b>60 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND</b>		First <b>R</b>	Middle <b>A</b>
4. DATE OF DEATH		Month <b>Jan</b>	Day <b>11</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MAY 10, 1891</b>		9. AGE (In years lost birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown (orphaned)</b>		14. MOTHER'S MAIDEN NAME <b>unknown (orphaned)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>123-45-6789</b>	
17. INFORMANT <b>Mrs Raymond Fisher, Denton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brothelial Asthma Chronic</b>		<b>10 yrs</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Asturo Sclerosis</b>		<b>46 yr</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Denton</b> (County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 10</b> , 1959, to <b>Jan 11</b> , 1959, that I last saw the deceased alive on <b>Jan 10</b> , 1959, and that death occurred at <b>34</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Denton, Md.</b> DATE SIGNED <b>1/12/59</b>			
ACTUAL SIGNATURE <b>Lawson George</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>DAWSON George</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 14, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Denton</b>		22d. LOCATION (City, town, or county) <b>Denton, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John George Dawson Denton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 19 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>John S. Knapp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.

## CERTIFICATE OF DEATH

Date of Birth

Date of Death

Cause of Death

Place of Death

Signature

Signature

Signature

Signature

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00428

433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) henderson		c. LENGTH OF STAY IN 1b 50 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Henderson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None			d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Charles	Middle A.	Last Griffith	4. DATE OF DEATH 1 10 19 59	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/5/1866	9. AGE (In years (sub/birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Luther Griffith		
14. MOTHER'S MAIDEN NAME Amanda Tribbett			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. 222-14-8990			17. INFORMANT Lola Grace Marvel Sudlersville Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1, 19 58, to Jan. 10, 19 59, that I last saw the deceased alive on Jan. 9, 19 59, and that death occurred at 4:15 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED Jan. 10 19 59					
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.					
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/59	22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire Greensboro, Md.			24a. REC'D BY REGISTRAR JAN 14 '59 DATE 24b. REGISTRAR'S SIGNATURE Charles S. Evans		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00427

434

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
CAROLINE MARYLAND		MARYLAND b. COUNTY CAROLINE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b 1 yr		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First ELLA	Middle FRANCES	
Last HACKERT		4. DATE OF DEATH	Month JAN, Day 1 Year 1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
7	W		JUNE 19, 1898	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EUGENE BALLAND		
14. MOTHER'S MAIDEN NAME STELLA [Unknown]		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO.		17. INFORMANT	Address	
-		Charles Hackert, Denton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Cardiac Failure				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous				
DUE TO (c) Carcinoma of the uterus				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from		10-24, 1958, to 1-1, 1959, that I last saw the deceased alive on 12-27, 1958, and that death occurred at 12 <sup>05</sup> AM, from the causes and on the date stated above.		
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) M.D. Federalburg, Md. DATE SIGNED 1-1-59		
PHYSICIAN'S NAME (Type)		H. R. Trapnell		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-3-58	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Pt. Cem.	22d. LOCATION (City, town, or county) BALTIMORE, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE McCullough Funeral Home		ADDRESS 130 E. Fort Me.	24a. REC'D BY REGISTRAR JAN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Tracy

139. — CERTIFICATE OF DEATH.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00428

435

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b 23 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Houston Branch Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural	
3. NAME OF DECEASED (Type or print) Paiza		d. STREET ADDRESS Houston Branch Road	
4. DATE OF DEATH January		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Ukraine		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Stephen Hryntko, Federalsburg, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 MINUTES GENERALIZED ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION; SENILE STATE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/19, 1959, to 1/7, 1959, that I last saw the deceased alive on 1/6, 1959, and that death occurred at 11 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. H. Beckert, M.D.</i> ADDRESS (Street, city or town, state) <i>Bridgeville, Del.</i> DATE SIGNED <i>1/9/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan. 9, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul Cemetery		22d. LOCATION (City, town, or county) Youngstown, Ohio (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland	
24a. REC'D BY REGISTRAR DAJAN 12 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knarr</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00429

## CERTIFICATE OF DEATH

436

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

CAROLINE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSLENGTH OF STAY  
(In this place)

45 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND

COUNTY

CAROLINE

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED

(Type or Print)

(First) GEORGE HERMAN

(Middle)

(Last) KOENIG

4. DATE  
OF  
DEATH

JAN 27 1959

(Month) (Day) (Year)

## 5. SEX

M

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

married

## 8. DATE OF BIRTH

APR 4, 1895

## 9. AGE last birthday

63 yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Restaurant owner

10b. KIND OF BUSINESS  
OR INDUSTRY

Food

## 11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME

Louis T. Koenig

## 14. MOTHER'S MAIDEN NAME

Emilia Neubert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Mrs George H. Koenig, Denton

INTERVAL BETWEEN  
ONSET AND DEATH

2 yr

18. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Chronic Myocarditis

## 420.1 IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Coronary myocardial infarction

2 yr

Coronary thrombosis, 2-26-56 and 1-24-57

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, lecery,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. While at work  Not while at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 8, 1956, to Jan 27, 1958, that I last saw the deceased  
alive on Jan 27, 1958, and that death occurred at 7:05 P.M. from the causes and on the date stated above.

SIGNATURE

E. Paul Koenig

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Jan 31, 1959

## NAME OF CEMETERY OR CREMATORI

Denton

## LOCATION (City, town, or county)

(State)

## 24. REC'D BY REGISTRAR

Arthur S. Koenig

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

Vivian Moore, Denton, Md.

## ADDRESS

## DATE FEB 3 '59



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00430

437

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
EDWOLDINE MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON		c. LENGTH OF STAY IN 1b X DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First WILLARD	Middle ERIC	Last LANE	4. DATE OF DEATH	Month Jan.	Day 12	Year 1959
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 4 1904	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME ROBERT E. LANE	14. MOTHER'S MAIDEN NAME LINDA WARREN
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		2 hr
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?
Hypertension 3 yrs		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
--	--	--

20c. TIME OF INJURY Month, Day, Year Hour o. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I attended the deceased from Oct 20, 1958, to Jan 12, 1959, that I last saw the deceased alive on Jan 12, 1959, and that death occurred at 9:40 AM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <i>Paul Knotts</i>	M.D.	Denton, Md
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PHYSICIAN'S NAME (Type) E. Paul Knotts M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 14, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Denton	22d. LOCATION (City, town, or county) Denton	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 20 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
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STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH—REGISTRATION

CERTIFICATE OF DEATH

REGISTRATION NO. 1000000000000000000

DEATH CERTIFICATE NO. 1000000000000000000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,14 Film G238 2-6-59 et

00431

438

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	GREENSBORO		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Tribbets Nursing Home		d. STREET ADDRESS	X RIDGELY					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year				
WILLIAM			LEWIS MITCHELL	JAN 21	1959				
5. SEX	M	6. COLOR OR RACE	W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	JAN 12, 1874	9. AGE (In years last birthday)	85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
ISAAC MITCHELL			MARYLAND			USA			
13. FATHER'S NAME	ISAAC MITCHELL		14. MOTHER'S MAIDEN NAME	Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	No		16. SOCIAL SECURITY NO.	17. INFORMANT		Edw Gallagher			
Address: Ridgely, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
420.1 DUE TO Coronary Thrombosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									
Arteriosclerotic Cardiovascular Disease. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY	Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour a. m. p. m.			19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from Oct. 1, 1956, to Jan. 21, 1959, that I last saw the deceased alive on Jan. 21, 1959, and that death occurred at									
M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
Greensboro, Maryland									
DATE SIGNED 1-24-59									
ACTUAL SIGNATURE: Charles H. Stonesifer, M.D.									
PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		State)			
Burial	Jan 25, 1959	Greenmount		Hillaboro, Md					
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
S. W. Denton	Denton		JAN 29 1959		S. W. Denton				

CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00452

439

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>8 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>South Main St.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> 0913-2	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b>Edward</b>	Last <b>Mowbray</b>
4. DATE OF DEATH Month <b>Jan.</b> Day <b>10,</b> Year <b>1959</b>	Month <b>19</b>	Day <b>19</b>	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1894</b>
9. AGE (in years last birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>police and guard work detective co.</b>	14. KIND OF BUSINESS OR INDUSTRY <b>work</b>	15. BIRTHPLACE (State or foreign country) <b>E. New Market</b>	16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
17. FATHER'S NAME <b>Edward Mowbray</b>	18. MOTHER'S MAIDEN NAME <b>Emma Reeves</b>	19. ADDRESS <b>Cambridge, Md.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary abscess</b> ? (c) <b>Atherosclerotic heart disease</b> ?			
INTERVAL BETWEEN ONSET AND DEATH <b>8</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-9-</b> 19 <b>59</b> , to <b>1-10-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>January 10</b> 19 <b>59</b> , and that death occurred at <b>1</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. R. Trapnell</b>			ADDRESS (Street, city or town, state) <b>126 Bloomingdale Avenue</b>
PHYSICIAN'S NAME (Type) <b>H. R. Trapnell, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1/12/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>E. New Market Cem.</b>	22d. LOCATION (City, town, or county) <b>E. New Market, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lawrence J. Hansen</b>		ADDRESS <b>Federalsburg, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>1-14-59</b>
			24b. REGISTRAR'S SIGNATURE <b>Charles L. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF EDUCATION - 11

CENTRAL STATE ORGANIZATION

622

NAME OF STATE

STATE

STATE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN 1b 55 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithville Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
3. NAME OF DECEASED (Type or print) Tristram		First Middle Downs	Last Nabb
4. DATE OF DEATH January	Month 8	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1873
9. AGE (In years lost birthday) 85 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Talbot County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Downs Nabb		14. MOTHER'S MAIDEN NAME Mary Elizabeth Matthews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Robert O. Dulin, Federalsburg, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Angina Terminal attack (c) DUE TO Cardiac Collapse.		INTERVAL BETWEEN ONSET AND DEATH 2 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 28, 1958</u> , to <u>Jan 7, 1959</u> , that I last saw the deceased alive on <u>Jan 9th</u> , 1959, and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 1-9-1959	
ACTUAL SIGNATURE W. E. Lennon, M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Jan. 11, 1959		22c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery	
22d. LOCATION (City, town, or county) East New Market, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JAN 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00434

441

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro - Rural		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Irving's Chapel Road				d. STREET ADDRESS Irving's Chapel Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clayton	Middle Andrew	Last Nichols	4. DATE OF DEATH January 20	Month January	Day 20	Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 6, 1899	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Federalsburg, Md., R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis H. Nichols		14. MOTHER'S MAIDEN NAME Sarah E. James					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-12-0988		17. INFORMANT Mary V. Nichols, 37 Cunard St., Boston, Mass.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		Carcinoma of the lung		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO					
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greensboro, Md.	(County) Caroline
21. I certify that I attended the deceased from Jan. 2, 19 59, to Jan. 20, 19 59, that I last saw the deceased alive on Jan. 20, 19 59, and that death occurred at 2 P. M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Greensboro, Md.		DATE SIGNED 1-23-59	
ACTUAL SIGNATURE Charles H. Stonesifer	PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 23, 1959	22c. NAME OF CEMETERY OR CREMATORI St. Paul Cemetery	22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 30 '59	24b. REGISTRAR'S SIGNATURE Charles H. Stonesifer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for future files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		442		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		d. STREET ADDRESS Reliance Road					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reliance Road				d. STREET ADDRESS Reliance Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Samuel		First	Middle	Lost	4. DATE OF DEATH January	Month	Doy	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 24, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics, Inc.		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Archibald Reagan		14. MOTHER'S MAIDEN NAME Georgeanna (maiden name unknown)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Reginald A. Reagan, Cambridge, Maryland		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Suffocation - Smoke 3rd Degree Burns - 1/2 Body Exposure		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bed caught fire from cigarette		20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-1 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Federalsburg	(County) Caroline	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE DAVISON D. GEORGE				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-9-59			
EXAMINER'S NAME (Type) DAVISON D. GEORGE		22b. DATE THEREOF Jan. 9, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR JAN 12 '59		24b. REGISTRAR'S SIGNATURE Orville S. Kraus							
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland									
VS. A15ME 5M 2/57		DATE									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00436

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE  Maryland		b. COUNTY  Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural Ridgely		c. LENGTH OF STAY IN 1b  50 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural Ridgely				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  None		d. STREET ADDRESS  None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)  George		First	Middle	Last	4. DATE OF DEATH  Taylor	Month 1	Day 22	Year 1959
5. SEX  Male	6. COLOR OR RACE  Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  7/18/1890	9. AGE (In years lost birthday)  68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY  None		11. BIRTHPLACE (State or foreign country)  North Carolina		12. CITIZEN OF WHAT COUNTRY?  U.S.A.		
13. FATHER'S NAME  No Record		14. MOTHER'S MAIDEN NAME  No Record						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No		16. SOCIAL SECURITY NO.  Unknown		17. INFORMANT  Mary E. Taylor		Address Ridgely, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1		DUE TO  Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO  Arteriosclerotic Cardiovascular Disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)  Greensboro, Md.	(County)  M.D.	(State)  Maryland		
21. I certify that I attended the deceased from alive on Jan. 22, 1959, and that death occurred at 6:50 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)  Greensboro, Md.		DATE SIGNED 1-24-59		
ACTUAL SIGNATURE  Charles H. Stonesifer M.D.								
PHYSICIAN'S NAME (Type)  Charles H. Stonesifer								
22a. BURIAL, CREMATION, REMOVAL (Specify)  Burial		22b. DATE THEREOF  1/25/59		22c. NAME OF CEMETERY OR CREMATORIUM  Denton		22d. LOCATION (City, town, or county)  Denton, Maryland		(State)  Maryland
23. FUNERAL DIRECTOR'S SIGNATURE  J. E. Boulaire		ADDRESS  Greensboro, Md.		24a. REC'D BY REGISTRAR  Jan 27 '59		24b. REGISTRAR'S SIGNATURE  Charles S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SALVATION ARMY

CERTIFICATE OF DEATH

201204

201204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00437

## 444 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Henderson		c. LENGTH OF STAY IN lb 25 Yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson				
3. NAME OF DECEASED (Type or print) Mary		First Elma	Middle Tzschoppe			
4. DATE OF DEATH Month 1		Day 19	Year 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/1871			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William Wiloughby		14. MOTHER'S MAIDEN NAME Martha Anders				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Harry Tzschoppe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		Address Henderson, Maryland				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 days				
(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MIDDLE FARM	(County) Greensboro	(State) North Carolina
21. I certify that I attended the deceased from <u>JAN 13, 1959</u> to <u>JAN 19, 1959</u> that I last saw the deceased alive on <u>JAN 19, 1959</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert H. Wright</u> M.D. <u>MIDDLE FARM</u> <u>JAN 21 1959</u>		ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type) <u>ROBERT H. WRIGHT M.D.</u>		22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 1/23/59	24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Boulae, Greensboro, Md.</u>		ADDRESS				

## CERTIFICATE OF DEATH

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